To: Chairs Gilchrest and Lesser, Vice Chairs Gaston and Dathan, Ranking Members Seminara and Case, and Distinguished Members of the Human Services Committee
From: Gabrielle Lessard, National Immigration Law Center
Date: February 14, 2023
RE: H.B. 6616, An Act Concerning the Expansion of Husky Health Benefits to Those Ineligible Due to Immigration Status (**support**)

The National Immigration Law Center (NILC) supports H.B. 6616, An Act Concerning the Expansion of Husky Health Benefits to Those Ineligible Due to Immigration Status, and appreciates the opportunity to submit testimony.

Founded in 1979, NILC is the leading advocacy organization in the United States exclusively dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. NILC is a nationally recognized expert in public benefits laws and policies affecting low-income immigrants, including the effects of public charge policies on this population. Our work is focused on issues that affect immigrant families' well-being and economic security: health care and safety net programs; education and training; workers' rights; and other federal and state policies affecting immigrants.

Access to Health Coverage is Essential for Connecticut

In Connecticut, as throughout the U.S., undocumented immigrants participate in the workforce at higher rates than the U.S.-born.[i] Immigrant workers played a critical role in maintaining access to essential services, including health care, food production, and transportation during the peak of the COVID-19 pandemic and continue to do so.[ii] Yet these essential members of our communities and their family members are often ineligible for health insurance options paid for by their tax dollars, including the Affordable Care Act and comprehensive Medicaid services, and are less likely to be offered health coverage by their employers.

This includes young immigrants who would be served by H.B. 6616. A 2021 report and survey of 1,021 grantees of Deferred Action for Childhood Arrivals (DACA) conducted by Prof. Tom K. Wong of the University of California, San Diego, United We Dream, and NILC identified that 343,000 in this population were working in essential jobs.[iii] The survey found that 34 percent of all DACA respondents lacked any form of health insurance, compared to the 10 percent found in the general population.[iv] Although grantees are broader than the population served by this

legislation, this survey demonstrates the extent to which young people are impacted by health care exclusions.

In addition to working many of a community's most important jobs, immigrant workers are significant contributors to a state's economy and tax rolls. In Connecticut, undocumented immigrants contributed more than $124 million in state and local taxes,[v] and a 2021 study found that DACA recipients alone contributed $21.9 million of these taxes, in addition to adding more than $136 million in spending power to the state's economy.[vi]

The High Cost of Uninsurance

As Connecticut's previous expansion for children demonstrated, lawmakers in the state recognize it is not just this economic interest that is important to the future of the state's community. This would hold true for this new expansion as well. Extensive research demonstrates that uninsured adults receive poorer quality of care, and experience worse health outcomes than those with insurance.[vii] Among young adults, traumatic injury is the leading cause of death and disability.[viii] Numerous studies have documented that uninsured trauma patients were more likely to die in the hospital and less likely to receive rehabilitative care than insured trauma patients, even after accounting for patient comorbidities and injury characteristics.[ix]

Mortality from cancer is also higher among the uninsured. The American Cancer Society reports that cancer is the fourth-highest cause of death among young adults. While cancer patients without insurance are typically diagnosed with more advanced disease, a recent study found that their mortality is higher at every stage of the disease than that of insured patients.[x]

Providing expanded eligibility to uninsured young adults would reduce the exposure to tragic health outcomes and unaffordable medical costs for those individuals and their families. It would also benefit the larger community.

When a state expands access to health coverage, health-related access and outcomes improve for both residents who were previously insured, as well as those who acquire coverage. This effect is not limited to improved treatment and control of communicable disease. Researchers have found that a higher community uninsurance rate leads to a higher probability of difficulty obtaining needed care for individuals with private insurance.[xi] One study showed that the amount privately insured patients pay for emergency department services increased with the percentage of uninsured community members.[xii] This effect may reflect a preference for physicians to practice in communities with fewer uninsured patients. Studies comparing states that did and did not expand Medicaid under the Affordable Care Act show that new internists preferred to practice in states that had expanded Medicaid.[xiii]

As the COVID-19 pandemic laid bare, we are all interconnected. Vital members of our communities should not be excluded from essential public services because of where they were born and how long they have been here.

Public Charge Should Not Be a Barrier to Pending Legislation

We understand that some legislators have expressed concerns about the relationship between expanded eligibility for health care and the public charge grounds of inadmissibility. As explained in this section, concerns about public charge should not interfere with individuals' access to affordable healthcare.

Public charge is a complex, and longstanding principle of immigration law. It is also narrow, as it does not apply to all individuals, and even those for whom it could, it has a limited definition and application. Starting with what it does do, according to federal statute and reiterated in a 2022 regulation on the issue, the general concept is that a person who is deemed likely to become a public charge in the future can be denied lawful permanent resident (LPR) status (also known as a green card).[xiv] People outside the U.S. can also be denied permission to enter. Many categories of immigrants, including refugees and persons granted asylum, are exempt from public charge.[xv]

Within the U.S., a person's likelihood of becoming a public charge is assessed as part of the application for LPR status. The public charge assessment looks at the totality of the applicant's circumstances.[xvi] It includes consideration of the applicant's receipt or likely receipt of **only two** categories of public benefits[xvii]:

- Public cash assistance for income maintenance, and
- Long-term institutionalization at government expense.

This is where it is important to note what public charge does not do. First, it does not look at benefits that are not part of these two programs. **Individuals' access of benefits under H.B. 6616 for services other than long-term institutionalization would not be considered in a public charge determination**.

Furthermore, having received or being deemed likely to receive one of the two categories of benefits is not dispositive. DHS will review any receipt of benefits along with the other factors in the totality of circumstances and will take into consideration the length of time and recency of any benefits receipt.[xviii] If a person who received long-term care services paid for by H.B.

6616 applied for LPR status, and that person was not exempt from public charge, the receipt of those services could be considered as a factor in a public charge determination. However, the magnitude of this risk is overwhelmingly outweighed by the benefits of ensuring access to essential healthcare services to Connecticut's uninsured young adults. It should also be up to the individual to make this assessment on what is best for their circumstances.

Conclusion

As previously stated, this bill would provide an important step toward health equity in Connecticut consistent with the values already followed by lawmakers in the state. The effects of this bill would have an important impact on the health and well-being of young adults, and it would support the workers and their families who are important contributors to the state.

Again, we appreciate the opportunity to provide testimony. Please reach out to me at lessard@nilc.org if I can provide additional information.

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[i] "State Immigration Data Profiles: Connecticut," Migration Policy Institute, https://www.migrationpolicy.org/data/state-profiles/state/workforce/CT// (last visited Feb. 13, 2023).

[ii] Julia Gelatt and Muzaffar Chishti, "COVID-19's Effects on U.S. Immigration and Immigrant Communities, Two Years On," Migration Policy Institute (2022), https://www.migrationpolicy.org/research/covid19-effects-us-immigration.

[iii] Nicole Prchal Svajlenka and Trinh Q. Truong, "The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition," Center for American Progress (Nov. 2022), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition.

[iv] Kat Lundie, et al., "Tracking DACA Recipients' Access to Health Care," NILC, https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf (last visited Feb. 13, 2023).

[v] Lisa Christensen Gee, et al., "Undocumented Immigrants' State & Local Tax Contributions," Institute on Taxation & Economic Policy (March 2017), https://itep.sfo2.digitaloceanspaces.com/immigration2017.pdf.

[vi] Svajlenka, supra n. iii.

[vii] *See, e.g.,* Steffie Woolhandler and David U. Himmelstein, "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?," Annals of Internal Medicine (Sept. 19, 2017), *available at* https://www.acpjournals.org/doi/10.7326/m17-1403; J Michael McWilliams, "Health consequences of uninsurance among adults in the United States: recent evidence and implications," Milbank Q. (June 2009)87(2):443-94 *available at* https://pubmed.ncbi.nlm.nih.gov/19523125/.

[viii] "Deaths and mortality, 2021," Centers for Disease Control and Prevention, National Center for Health Statistics, https://www.cdc.gov/nchs/fastats/deaths.htm

[ix] *See, e.g.,* Gerry JM, Weiser TG, Spain DA, Staudenmayer KL, "Uninsured status may be more predictive of outcomes among the severely injured than minority race." Injury (Jan. 2016) 47(1):197-202, *available at*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4698055/; Sacks GD, Hill C, Rogers SO Jr. "Insurance status and hospital discharge disposition after trauma: inequities in access to postacute care," J Trauma (Oct. 2011) 71(4):1011-5, *available at* https://pubmed.ncbi.nlm.nih.gov/21399544/.

[x] Jingxuan Zhao, Xuesong Han, Leticia Nogueira, Stacey A. Fedewa, Ahmedin Jemal, Michael T. Halpern, K. Robin Yabroff, "Health insurance status and cancer stage at diagnosis and survival in the United States," CA: A Cancer Journal for Clinicians (Nov/Dec 2022) Volume 72, Issue 6, 542-560, *available at* https://acsjournals.onlinelibrary.wiley.com/doi/10.3322/caac.21732.

[xi] Carole Roan Gresenz , José J Escarce, "Spillover effects of community uninsurance on working-age adults and seniors: an instrumental variables analysis," Med Care (Sep. 2011) 49(9):e14-21., *available at* https://pubmed.ncbi.nlm.nih.gov/21865890/

[xii] Kirby JB, Cohen JW, "Do People with Health Insurance Coverage Who Live in Areas with High Uninsurance Rates Pay More for Emergency Department Visits?" Health Serv Res. (Apr. 2018) 53(2):768-786., *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5867177/.

[xiii] Escarce JJ, Wozniak GD, Tsipas S, Pane JD, Brotherton SE, Yu H., "Effects of the Affordable Care Act Medicaid Expansion on the Distribution of New General Internists Across States," Med Care (July 1, 2021) 59(7):653-660, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8191468/.

[xiv] *See* 8 USC § 1182(a)(4).

[xv] 8 CFR § 212.23(a).

[xvi] 8 CFR § 212.22(b).

[xvii] 8 CFR § 212.21(a).

[xviii] 8 CFR § 212.22(a)(3), (b).